Chapter 3
Stigma and Misconceptions of Poverty Reduction

ABSTRACT

This chapter examines the notions of stigma, bias, and myth of poverty reduction and focuses specifically on rural poor populations in nations that fell behind in implementing the global targets of poverty reduction, the majority of them in Sub-Saharan Africa. The task is to examine various characterizations of myth and stigma in historical discourse and explain the processes and mechanisms by which myth and stigma function as a mediator of various tensions within historical discourse. First, this chapter describes the characterizations of stigma and the misconceptions of poverty; second, it explains the barriers and the daunting task of poverty reduction; and third, it shows how negative perceptions of poverty ultimately complicate the implementation of the poverty reduction agenda.

INTRODUCTION

Stigma, bias, myth, and the misconceptions of poverty reduction are widespread and run deep in Africa. If conflicts, political disappointments, social and economic development hurdles and negative perception issues of poverty are not taken up by global governments, myriad challenges lie ahead of the poverty reduction hard work. In particular, poverty assistance and the overall poverty alleviation programs face formidable hurdles because of misconceptions, stigma, bias, and a persistent misunderstanding of the poor (Kerbo, 1976). For these reasons, poverty reduction is at a crucial moment of its global efforts. It is now well recognized that more attention must be paid to the various factors and processes which either constrain or enhance poor people's ability to make a living in an economically, ecologically, and socially sustainable manner (Krantz, 2001).

A cyclical explanation of poverty plainly looks at the individual situations and the community resources as mutually dependent, and when caught in a spiral of opportunity and problems, and that once problems dominate, they close other opportunities and create cumulative set of problems that make any effective response nearly impossible (Bradshow, 2007). To break the cycle of poverty, programs must be comprehensive, must involve collaboration among different organizations including the local people as

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well as community organizing, where the local people can participate to understand how their personal lives and the community well-being are intertwined.

Some of the conservative views on poverty reduction efforts have been found to be too narrow because they focused only on certain aspects or characterizations of poverty, such as low income, calorie consumption, or did not consider other vital aspects of poverty such as vulnerability and social exclusion. Some of the arguments in the current literature have shown that the causes of poverty are inadequate primarily because they assume that individuals are themselves to blame for the poverty situation, they find themselves (Bradshow, 2007). These accounts of poverty as individualistic or structural causes (e.g., poverty as a consequence of economics, politics and cultural factors in society) or fatalistic (e.g., poverty as the result of illness, mental health, or bad luck) need to be expanded to include other manifestations of poverty, such as stigma, bias, or outright discrimination. This chapter addresses the gap in the current literature by situating poverty reduction in the historical discourse of myth, bias, and stigma.

Social science research on stigma situates stigma within the co-occurrence of its components, namely—labeling, stereotyping, separation, status loss, and discrimination—and further indicate that for stigmatization to occur, power must be exercised (Parker & Aggleton, 2003). That is, essentially, the way resources and other livelihood opportunities are distributed locally is often influenced by informal structures of social dominance and power within the communities themselves.

For example, the Ministry of Health and Social Welfare of the Tanzania government commissioned a wide-ranging review of the operation of health cost exemptions and waivers (Burns and Mantel 2006). The authors of the report argued that the current exemptions system may, in fact, favor the better-off more than the poor since most of those exempted belong to households which are able to pay membership fees of the Community Health Fund (CHF). They suggested that the poorest often do not have access to waivers, either due to a lack of information or denial of the waiver by a provider. In addition, it is argued that the approach in and of itself has loopholes that allow misuse and, sometimes, abuse of the system, and lengthy and cumbersome identification processes often deter people from applying (Burns & Mantel 2006).

In this particular case, perhaps lack of specification of criteria by which the poor could be identified introduced bias into the process and made policy implementers at different levels to implement the policy in their own style. Low level of public awareness about the existence of waiver mechanisms hindered the poor to demand exemptions (Idd, Yohana, & Maluka, 2013). Perhaps, it is for the fear of loss of revenue at the health facilities and the ineffective enforcement mechanisms, that collectively provided little incentives for local government leaders and health workers to communicate the policy to beneficiaries. Although studies on the implementation of exemption policies in Tanzania exist, very few have documented the actual process of translating exemption policies into actions; that is, the process of implementation (McGillivray, & White, 1993). Worthy of note here is the lack of specification criteria to determine who is poor and who is not. Without a clear definition of who is poor and merits exemption, it becomes difficult to know who is really poor or extremely poor, and consequently, who can demand exemptions.

Furthermore, Burns and Mantel's (2006) study concluded that to better achieve the objectives of the pro-poor exemption policy, it is important to engage policy implementers more actively in the management and implementation of pro-poor policies. Additionally, it is essential to understand the attitudes, behaviors and practices of policy implementers, especially district health managers, health workers and village and ward leaders, who may not be sensitive to the needs of poor people or react negatively to new policies and implement the policies in ways contrary to what policymakers had intended.